DENTAL PLAN ENROLLMENT/CHANGE REQUEST

PLEASE COMPLETE AND RETURN THIS FORM TO:

CalPERS, HEALTH BENEFIT SERVICES DIVISION
P. O. BOX 942714
SACRAMENTO, CA 94229-2714
Phone No: 1-888-225-7377 FAX: (916) 795-3198 or **(916) 795-3231**

2008 RETIREE DENTAL OPEN ENROLLMENT

IF YOU HAVE NO COVERAGE CHANGES -- DO NOT RETURN THIS FORM

MEMBER'S SOCIAL SECURITY NUMBER -- --	SPOUSE'S OR DOMESTIC PARTNER'S SOCIAL SECURITY NUMBER -- --

NAME IN FULL (First) (Middle) (Last)

YOUR MAILING ADDRESS

(NUMBER & STREET) _____

(CITY) _____

(STATE & ZIP CODE) _____

SEX	MARRIED	DOMESTIC PARTNERSHIP
❒ Male	❒ Yes	❒ Yes
❒ Female	❒ No	❒ No

Your Birth date: ____/____/____

DAYTIME TELEPHONE NUMBER: ( )

NAME OF DENTAL PLAN: _____ (For enrollments or plan changes)

NAME OF PRIOR STATE DENTAL PLAN: _____ (For plan changes only)

IF CHOOSING A PRE-PAID PLAN ENTER THE NAME OF THE FACILITY NUMBER:

NAME OF ELIGIBLE DEPENDENTS	BIRTH DATE	RELATIONSHIP

NOTE: To enroll a spouse, you must attach a copy of your marriage certificate and provide your spouse's Social Security Number. To enroll a Domestic Partner, you must attach a copy of the Secretary of State's required filing documents and provide your partner's Social Security Number. Dependents, including dependents of domestic partners must be listed (name, birth date and relationship to retiree)

1. ❒ PLEASE CANCEL MY COVERAGE ON A PROSPECTIVE BASIS. I DO NOT WISH TO BE ENROLLED IN A DENTAL PLAN OFFERED TO ME AS A STATE RETIREE. **(Check box)**

2. ❒ I ELECT TO ***ENROLL/CHANGE*** TO THE DENTAL PLAN INDICATED ABOVE, AND/OR ***ADD/DELETE*** ELIGIBLE FAMILY MEMBERS. I ALSO AUTHORIZE DEDUCTIONS, IF APPLICABLE, TO BE MADE FROM MY RETIREMENT ALLOWANCE TO COVER MY SHARE OF THE COST OF ENROLLMENT AS IT IS NOW OR AS IT MAY BE IN THE FUTURE. **(Check box and Circle election)**

3. SIGNATURE:	DATE FORM SIGNED: Month | Day | Year

Revised 07/08

The Information Practice Act of 1977 (Civil Code Section 1798.17) and the Federal Privacy Act (Public Law 93-579) require that this notice be provided when collecting personal information from individuals.

Information requested on this form is used by the Department of Personnel Administration and the dental insurance company for the purpose of identification and dental coverage processing.

It is **mandatory** to furnish all information requested on this form. Failure to provide the **mandatory** information may result in the dental enrollment action not being processed or being processed incorrectly.

The Department of Personnel Administration requires social security number and name for identification purposes. Legal references authorizing maintenance of this information include Government Code Sections 1151, 1153, Sections 6011 and 6051 of the Internal Revenue Code, and Regulation 4, Section 404.1256, Code of Federal Regulations, under Section 218, Title II of the Social Security Act.

Information provided on the form will be forwarded to the dental company providing coverage. Copies of the RETIREE DENTAL PLAN ENROLLMENT/CHANGE REQUEST form are maintained in confidential files of the California Public Employees' Retirement System (CalPERS) for five years. Individuals have the right of access to copies of their RETIREE DENTAL PLAN ENROLLMENT/CHANGE REQUEST form upon request. Send requests to: California Public Employees' Retirement System (CalPERS), P. O. BOX 942714, SACRAMENTO, CA 94229-2714, Attn: Health Benefit Service Division.